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ABSTRACT

This document contains 11 papers from the ninth World Conference of Therapeutic Communities (TCs) that deal with management issues and innovations within TCs. Papers include: (1) "Support or Restriction of TCs: Governmental Interation vs. Self-Reliance" (Richard Pruss); (2) "Governmental Support: A Swedish Perspective" (Lars Bremberg); (3) "Delancey Street Foundation: An Example of Self-Reliance" (Mimi Silbert); (4) "Threat to National Security: Drugs in the Workplace" (Lois Morris and Anthony Miles); (5) "Computer Technology & the TC" (David Kerr); (6) "Automating Quality Control: Residential & Outpatient Settings" (Richard Anderson and G. G. DeAngelis); (7) "EAP Programs Can and Do Work in a TC" (Allen Bray); (8) "What Employee Assistance Programs Expect from Drug Programs" (Larry Levy); (9) "Enterprise in the Non-Profit Zone (Joseph Diament); (10) "TC or TLC: An Identity Crisis" (John Brewster and Jesse Jaramillo); and (11) "The Para-Professional vs. the Professional: Breaking the Barrier" (Logan Lewis). (NB)

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CHAPTER 10

MANAGEMENT ISSUES & INNOVATION

SUPPORT OR RESTRICTION OF TC'S: GOVERNMENTAL INTERACTION/SELF-RELIANCE

Richard Pruss

Samaritan Village Inc.,
Queens, New York

Let's start with a simple scenario. Let's imagine that, eight days ago, there was another catastrophic earthquake and fire here in san Francisco. Let's imagine that blocks of the city are rubble and ruins, that a state of emergency has been declared and that health authorities have identified a serious outbreak of typhoid fever; they fear an epidemic. Alarmed and confused citizens, struggling to cope with everything else, naturally want to know how they can protect themselves and their families from disease.

Soon there are official announcements on TV, on radio and in the newspapers. Posters and fliers are circulated throughout the stricken city. They say:

Citizens: Your government is concerned about the medical emergency. Here are your instructions: 1) If you feel ill, make an appointment with your private family physician. Be sure to take your medical insurance ID and forms with you. 2) If you do not have health insurance or other means of paying for health care, stay home. We hope you will not become ill. If you do, do not call your government. 3) Contribute generously to the private hospital or other health facility of your choice. Your government is doing all it can to avoid competing with private health care providers. This announcement will not be repeated.

End of scenario. It's all imaginary. Nothing like that would ever happen in a real public health emergency. Unless, of course, we talk about the plague caused by drug abuse, a public health crisis by any definition. In that case, the fantasy I have just described begins to sound unpleasantly real.

The crisis I mean is not localized in one city; it has reached into them all -- and beyond them. We don't have to imagine the costs -- in human life, in property destruction, in other economic losses. And the critical need for skilled treatment is equally real. We are dealing in every way with a pandemic condition. But when we come to the issue of federal government support for drug abuse treatment, the prevailing policy is clear: Don't get sick. If you do, don't call your government.

In recent years, federal assistance to our service programs have been decimated four times over. We have lost 42% in real dollars during this period, but there is only limited public perception of that devastating damage. At the same time, Mrs. Nancy Reagan has become increasingly identified in the public mind with the fight against drug abuse, particularly on behalf of the young. She is a frequent visitor to programs and is warmly received by them. Earlier this year, she convened an international gathering of first ladies from around the world to express their concern about drug abuse; during their visit to the United States, they were guests of a privately supported treatment program in Atlanta, Georgia.

Mrs. Reagan has also been cordially received and honored by major TCA programs, including those supported by public funds, chiefly state funds. But her strong emphasis on the primary role of "the family" in deterring drug abuse and her strong encouragement of volunteer effort reveal distinct opinions about publicly supported human services programs in contrast to private ones.

The crippling of needed treatment programs has gone on. And Mrs. Reagan's responses to direct questions about the obvious inconsistencies have not always been forthright. This past spring, for example, ABC TV's Joan Lunden asked," Some people in the drug abuse field, while they are very quick to praise you and what you have done to keep the subject of drug abuse in front of the public, are critical of the Reagan administration's cut in federal spending on drug abuse programs. What do you say to them?" Mrs. Reagan's reply was, "Oh, I think their confusion lies in the change to block grants. They gave the money to the states rather than administering it from Washington. They didn't cut back; they gave it to the states. So, now it's up to the states," she added.

In fact, as I've made clear, federal funds have been drastically cut back, in accordance with an administration domestic policy that has been consistently hostile to human service programs at every level. Furthermore, states which have tried to offset these and other losses have been targeted for renewed attack. As the White House Communications Director, Patrick Buchanan, asserted late this spring, the administration's tax reform program was intended, in part, to discourage states from a "neo-socialist approach to government."

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All this is part of current history. And as we recall it this morning, I'm sure there are colleagues of his who are thinking, "Well, what's new? What one politician gives you, another can take away. We teach our clients self-help and independence. We have to run our programs that way or we become funding junkies."

That is a serious concern and it has to be addressed as we face the main issues this morning: Hos is state-of-the art drug abuse treatment going to be provided to the millions of Americans who need it and how will it be paid for? With public funds? With private money? With help from both these sources? No other single issue is more critical to our field because none of our skill, none of our experience, none of our carefully developed ability to save lives can be brought to bear unless there are realistic answers to urgent questions about support of treatment.

Of course, there was a time, within easy memory of many of us here, when there wasn't any funding issue. My home agency, and many others exploring the new field of drug abuse treatment, had as little money as experience. We managed, most of us, on small contributions, on the help of volunteers, on donations of secondhand clothing and furniture, on the good will of a few sympathetic people who would offer a roof and a room for nothing. Self-reliance was not a subject for discussion, it was the only way to survive and serve.

In the same way, we relied on ourselves in developing our programs. Medical professionals were skeptical. Mental health professionals were skeptical. Much of the public was either doubtful or hostile to us. But we persisted, and over a generation, we have firmly established a new human services profession, productive and growing. It is now ready, at the time when it is most needed, to care for great numbers of men and women.

We cannot meet that obligation, however, if we are obstructed, hobbled and undermined by official policies based on the idea that private enterprise can be substituted entirely for the kind of public services we provide and that voluntary effort, family concern, "tough love" and other formulations are not only essential for prevention and education, but also enough to assure treatment.

Can the United States do all that needs to be done, socially and economically, medically and psychologically, to treat substance abuse by leaving the whole responsibility to the resourcefulness of privately supported providers?

That is the question. And the answer is, "No."

Is there some reason why expert treatment for drug abusers who cannot afford private-pay or insured health care should be regarded as markedly different from other forms of public health care? That is another major question. And the answer, again, is "No."

Are any of us really free of government regulation now? Do we operate, in any state, without appropriate oversight as responsible community health care providers? No, we don't. On the contrary, we are, most of us, used to meeting official standards and we are often on good professional and personal terms with the people in government who establish and enforce them.

Let me elaborate on some of these questions and answers. The scope of the problem, first of all, is impossible to ignore. There is no accurate estimate of the number of seriously afflicted drug abusers in this country, but no region of the economy is drug-free. In preparing these remarks, I leafed casually through New York daily newspapers for a week, looking for stories about drug abuse and abusers. They came from the fields of professional sports (baseball and basketball), from the film industry, from secondary education, from law enforcement, from corrections and from the judiciary. Yes, many of these abusers can afford private treatment services. Yes, many of them could qualify for treatment through employee assistance programs. But there are multitudes of Americans, including middle class individuals, who will either have treatment that is largely supported by public funds or will not have treatment at all.

That is true of health care generally today. It is, as I've indicated, equally true of substance abuse care. The community-based program, over decades of development, has proved itself an economical, effective alternative to the utterly worthless "detox and discharge" approach which once constituted the federal government's treatment program.

And the same originality and ingenuity that has been characteristic of therapeutic program development is just as obvious in the variety of approaches we take to assure financial support and stability. Some of us function with no public funding of any kind, some of us work with a combination of public and private support. Some of us function with no public funding of any kind. Some of us work with a combination of public and private support. Some of us depend almost entirely on government contract support. Some of us operate successful businesses which can serve several positive purposes: meeting community needs for goods and services, giving clients valuable voc/ed experience and also the sense of achievement that is critical to successful therapy. Some of us -- my program is one -- face a relentless, heavy demand for human services from a huge volume of prospective clients in localities where there is always a surplus of unskilled and semi-skilled labor. For us, successful treatment demands not only recovery from drug abuse, but also that we supply top quality education and job skills. That can't be a part-time job, and private funding isn't enough to support it. So my program, and others like it, have special obligations when it comes to involving clients in fund-raising. Early this year, for example, we started planning for our annual raffle. Raffling is popular in

New York; there are some programs that raise most of their income from it, and Samaritan's young people do well at making money and making new friends for us.

But, as we've done in the past, we set a $100,000 cap on the raffle. We think that's realistic. Samaritan needs community support, but our clients need to become more self-supporting. That, I think, is the fundamental obligation we all have. All of us must meet our responsibilities to people in treatment. Those who can do this successfully and independently, with the help of their clients, deserve attention and respect. So do those who must rely on public funds to turn former drug abusers into useful private citizens. In fact, I would argue that the public's stake in this process is so clear and urgent that government should assume a reasonable share of the support of every accredited drug abuse treatment program now functioning -- exactly as it does in assisting a wide range of health, education and social programs.

Am I actually going to use the word "entitlement" in this connection? Yes, I am. There is no other rational answer to the obvious needs for service.

Now, let's look a little more closely at the "overregulation" issue. At my agency, one of the principal assignments of the Vice President for Administration is to maintain full compliance with local, county and state health care standards. We not only manage to do this, we thrive.

The reason is that we are continuously enlarging and extending health services. For instance, we decided early that our residential facilities should qualify as diagnostic and treatment centers under the New York State health law. This responsibility was not forced on us; we looked for it because we were determined to improve our program. I am sure that sense of professional commitment is shared by everyone here and that many of you have taken the same approach.

Moreover, as we have, you have made associations with elected and appointed officials. "Government" is not some grim and threatening abstraction; rather, it is embodied in often conscientious and helpful public servants who share your sense of obligation to help when there is no other source of help, who are determined that contracted services will be first-quality services.

In other words, "regulation" does not inevitably mean "overregulation" any more than receiving public support means an end to private initiative and innovation.

Against this larger background which I have sketched, I do not see that there should be either controversy or contention over program support, nor attempts to set up standards of acceptability, nor claims of superiority for one approach over another.

As professionals, we all welcome the opportunity to innovate, to develop, to reach new people in need. We can share our research, exchange our experience, extend the boundaries of our whole field. We can respect each other. I believe we do.

GOVERNMENTAL SUPPORT: A SWEDISH PERSPECTIVE

Lars Bremberg, M.A., L.L.M.

Vallmotorp, Daytop Sweden
Katrineholm, Sweden

Sweden is a welfare state, and this predetermines the rules for our TCs. The aim of the Welfare State is to guarantee citizens a high, secure and equal standard of living. To obtain this a strong sector for government and local government activities is needed. It requires a well developed bureaucracy to organize and control the system, and various fields in society will be run as state monopolies. In Sweden, the medical and social welfare sections constitute such monopolies. As a consequence, the treatment of alcoholics and drug addicts is considered a task for central or local government and private operators are allowed only if they follow the rules.

When a new need occurs, like alcoholism 70 years ago or drug addiction in the 60s, the government often uses state subsidizing to stimulate the creation of facilities, although this is mainly directed to local government agencies. As the production and sale of alcohol is a state monopoly, it has long been considered a moral obligation for the government to cover most of the costs incurred in the treatment of alcoholics. However, there is at present a tendency to depart from this costly tradition. The running of day centers for children, home services for the elderly and the rehabilitation of drug addicts have lately been such fields in focus. The economic support is usually withdrawn when the expected results are obtained. The Vallmotorp foundation received state subsidies at its start in 1973, but the subsidy value has gradually diminished with the impact of inflation and it will disappear completely by the end of this year; a fact that we are considering bringing to the notice of the courts.

It is not, however, the support that has been responsible for restrictions which TCs, such as Vallmotorp and Daytop Sweden, run by private, non-profit tax-exempt organizations, have been made to suffer, but rather the control that a number of central and local government agencies are exerting mainly in respect of localities, fire protection, plumbing, and so on. Nonetheless, we have always been one step ahead of the government as far as the treatment program is concerned, and so far fortunately, there has been a general acceptance that organizations like ours -- free from bureaucratic restrictions when running a treatment program -- are more successful and lead the way in the development of methods. They are, on the whole, more effective at a lower price.

In the end, of course, it is the taxpayer who has to provide the money, as clients themselves, or their families, can seldom do more than contribute a small portion of the treatment costs.

Thus, our income is made up of about 90% fees paid by local government welfare agencies. This means that we operate on a market where we have to present a good product at an attractive price, otherwise we will, pretty soon, be out of business.

This is the extent of the acceptance of private rehabilitation programs in the welfare state.

DELANCEY STREET FOUNDATION: AN EXAMPLE OF SELF-RELIANCE

Mimi H. Silbert, Ph.D.

Delancey Street Foundation, Inc.
San Francisco, California

Delancey Street is considered one of the most unique and successful programs in the country. We currently have over 600 residents located in four facilities throughout the country: San Francisco, where we've been for the past 15 years; on a 17-acre ranch in rural New Mexico, where we incorporate a juvenile program with one designed for adults, in operation for seven years; a large castle and several surrounding buildings on 90 acres in Brewster, New York, about 45 minutes outside of Manhattan, where we've been in operation for four years; and our newest Delancey Street in Los Angeles.

Our population ranges from ages 12 to 68; approximately 1/4 women; 1/3 Black, 1/3 Hispanic, and 1/3 Anglo. Despite the violence in the backgrounds of our residents, there has never been one incident of physical violence in Delancey Street, nor has there ever been one arrest.

We have graduated thousands of men and women into society as tax-paying citizens leading successful lives, including lawyers, realtors, sales people, the various medical professions, truck drivers, mechanics and garage owners, general plumbing and electrical contractors as well as many in the trade unions, printers and business managers, prior president of the school board, member of the San Francisco Board of Supervisors, and even a deputy sheriff.

Our successes have been touted by such notaries in the field as Karl Menninger, along with many of the media, including a 60 Minutes segment, a segment on CBS Morning News, The Today Show, a number of nationally circulated periodicals, many commendations from state legislatures, professional organizations, local majors and boards of supervisors in areas in which Delancey Street resides, along with commendations from professionals ranging from law enforcement through community agencies.

One of the most unique features of Delancey Street is that we have never accepted any government funds in the 15 years of our existence, nor do we have any staff. Aside from its president, everyone else in Delancey Street is also a resident in the process of changing their lives. No salaries are paid, not even to the president of the Foundation. Instead, everyone works. Everyone is both a giver and a receiver in Delancey Street. The Foundation supports itself primarily through a number of training schools which provide vocational skills to all the residents, and also, through pooling the monies earned, generate the Foundation's income.

Although we recently closed our restaurant in San Francisco, we still maintain ten other training schools, including: catering, an automotive training school (and antique car restoration); Christmas tree lots; a construction school; a moving school; a national trucking operation; printing and buttons production and sales; furniture, small wood products, bark planters and terrarium production and sales; a national advertising specialty sales department; and a paratransit service for seniors and other mobility impaired clients. Because the residents perform all the functions of Delancey Street themselves, there are numerous other departments which function as vocational training for residents but which do not provide any income because they serve simply in-house functions. These include bookkeeping and accounting departments, legal affairs, education, food service, secretarial skills, and computer skills, among others.

Catering Company

Our catering company provides full catering services both through the use of our own facilities and transported to other facilities. Catering offers a wide range of products, from hors d'oeuvres to full ten-course sit-down dinners provided for as many as 500 guests. Along with the production and service of food, catering includes the decorations and entertainment entailed in planning the events we service, including weddings, proms, business seminars, and specialty dinners.

The catering department trains approximately 30 people per year in menu developing and planning, food purchasing and preparation and serving, facility decorating, rental and estimating, and other skills.

Automotive Department

Our automotive department provides complete instruction in basic auto mechanics, oil changes, tire changes, tune-ups, routine general maintenance and complete engine repairs for over 30 residents yearly. Students work on a wide range of vehicles from passenger cars to diesel rigs, tractors and heavy duty equipment. Automotive services over 100 vehicles at any given time. In addition to mechanics and body work, it offers practical experience in antique car restoration. To date the Foundation has refurbished eight antique cars, learning engine and chassis rebuilding, electric wiring, body work, painting and upholstering. Numerous of our antique cars have won prizes in various Concours d'Elegance competitions.

Christmas Tree Lots

Delancey Street maintains six Christmas tree lots throughout the Bay Area. conducted each year only between Thanksgiving and Christmas, this brief holiday promotion is, nevertheless, the source of a significant share of our total earned income. Also significant are the diversity and complexity of merchandising skills it calls into play, among them on-site selection of prime stock from Pacific Northwest tree farms, construction of tree stands,and providing sufficient personnel, supplies, and equipment to ensure maximum operating effectiveness, timely delivery to each lot site of trees chosen for suitability of size, type, and price, accountability for cash receipts, security and ongoing maintenance of leased properties. The operation of the lots themselves and sales of Christmas-related products to banks and businesses involve the training of about 75 residents each year.

Construction School

All Delancey Street residents and business enterprises are housed in structures brought up to acceptable occupancy standards and building code specifications solely through the efforts of our construction school workmen and women under the direction of residents holding contractors' licenses. Each of the Foundation's four sites reflects architectural disciplines unique to its cultural and geographic influences; each has been enhanced through the introduction of improvements (restoration, remodeling, rehabilitation, new construction) conceived and carried out by resident craftsmen. Significant among ambitious projects adding immeasurably to each property's esthetic and monetary value are:

1) The restoration of a Tudor-inspired stone castle, two pre- Revolutionary War dwellings and an abandoned carriage house, all evocative of upper New York state at the turn of the century;

2) Complete restoration of four buildings in San Francisco, including a stately Edwardian mansion for which a self-taught Foundation artisan created, assembled, and installed a series of stained glass windows;

3) The complete renovation, including new floors, ceilings, walls, all new bathrooms and kitchens, of a former hotel and restaurant currently housing over 200 residents;

4) The remodeling, inside and out, of an uninhabitable apartment building in Los Angeles;

5) Construction by the Foundation's New Mexico work force of a 40,000 square foot business complex which accommodates a laundry, an automotive service center, a print shop, a sewing shop, officer and conference rooms; and a complete catering kitchen, built entirely in the authentic Southwest style. In fact, this building is the largest new edifice built in this style in the history of New Mexico;

6) Construction and installation on DSF/NM grounds of a completely self-sufficient sewer system and water treatment plant capable of serving a town of 5,000 people;

7) Construction of two large dormitories around a central courtyard, complementing the Southwestern flavor of existing buildings;

8) Additional new construction in New Mexico to provide six apartment units and an industrial facility incorporating a garage, several offices, and a large workshop.

Moving School

The Delancey Street moving school has been in operation as a fully licensed and insured mover with the statewide authority in California for 13 years. It consists of 40 fulltime experienced movers, with a labor pool of another 50 people. Our fleet consists of 112 bobtail moving trucks 24 feet long, 3 big rigs with 45-foot electronic vans, and 1 28-foot electronic van. The school designs and constructs all of its own dollies and other rolling stock. The Delancey Movers provide full service moves which include packing and crating safes and pianos.

Current contracts held include the G.S.A. term contract for the entire Bay Area, the term contract with the City and County of San Francisco, the term contract with Caltrans District IV, along with numerous other individual contracts, and, of course, the movement of household goods throughout the state. The largest single job completed by the school was for the U.S. Geological Survey, which consisted of 2.5 million pounds of geological samples and related equipment. The move took 82 working hours and was accomplished without a single instance of damage.

National Diesel Trucking

The national diesel trucking operation consists of classes for students conducted on a year-round basis and includes knowledge of and practice in the operation of diesel tractors. Delancey Street's diesel rigs runs regular circuit from San Francisco to Los Angeles to New Mexico to New York and return on a continual basis, requiring not only truck driving skills but knowledge of Interstate Commerce Commission rules as well as those enforced by state and local regulatory agencies.

About 50 men and women are trained and licensed in trucking skills each year.

Print Shop

Delancey Street's print shop not only generates income by making its services available to local merchants, it draws from the same resources to meet recurring Foundation requirements for stationery, printed forms, invitations and advertisements. On-the-job training entails every aspect of printing technology from image preparation to product finishing.

Most recent of our income ventures is based on the design, manufacture and sale of imprinted buttons. Personnel are taught such procedures as inventory control, order processing, assembly, and shipping. They work closely with the print shop and art department technicians.

Buttons are sold both as advertising specialty items and wholesaled to stores (for example, in the tourist areas of cities as well as hospital gift shops, college book stores, etc.).

Craft Products

Delancey Street is gaining a reputation for its finely worked craft products. For 13 years Delancey Street has developed its own bark planter products, which it has wholesaled to various nurseries along with terrariums. Delancey Street designs and hand crafts sand paintings, stained glass windows, furniture made in the Taos style, and numerous other hardwood items. These are produced completely by Delancey Street residents and are sold by residents to both wholesale and retail markets throughout the country. Over 50 people are trained in this department yearly.

Marketing Department

Delancey Street maintains a large marketing department which has a number of components. Residents are trained to sell to businesses corporate recognition gifts, service and safety awards, and sales incentives. These products are used by many companies as a means of keeping their names constantly in front of their customers. Because we are members of the Advertising Specialty Association International, we have access to the product lines of over 2,000 suppliers. Salespersons travel to businesses throughout the country. In addition to the sales of the products, we maintain our own record keeping and order processing departments, as well as an art department capable of creating the special art work needed for many of the products.

We have developed a specialty market in this field with college book stores, maintaining a product line imprinted with school emblems and sorority and fraternity insignia for resale in school book stores. This college market services over 1,500 college and university stores. Currently each of our Delancey Street locations services our clientele by regions. The New York sales office services New England and the mid-Atlantic states; New Mexico services Texas, the Midwest, and the South; our Los Angeles office services Southern California and the Southwest; our San Francisco office services Northern california and the Northwest.

We also have established accounts in the retail market from all four locations. These products include the Lou Broc line of sports miniatures and numerous impulse items such as Trivia games, particularly for discount drug stores, airport gift shops, and military exchanges in an ever-expanding market. The National Advertising Specialty Department is our most sophisticated training concept. We are able to train about 60 personnel, traveling locally and throughout the country, annually.

Paratransit

Paratransit training is an exciting project for Delancey Street because through it we were able to turn a volunteer service into an actual skills training and income generating situation. For the past ten years, Delancey Street has escorted senior citizens and provided entertainment and activities, including a weekly dinner at one of our facilities for numerous seniors in the community. For the past two years, Delancey Street, under contract to the Public Utilities Commission and the City and County of San Francisco, has been providing unlimited group van service for handicapped, elderly and disabled residents who are unable to use public transportation by themselves and who are thus certified by the city to use paratransit services.

Delancey Street's service is unique in that we provide trained escorts in addition to trained drivers on each van, and we have already received several mayoral and agency certificates and proclamations because we were able to save lives through quick action and CPR training while accompanying seniors on the vans.

About 25 residents are trained in this fulfilling marketable skill throughout the year. Upon graduation they are able to provide transportation service not only for seniors and mobility impaired clients, but for general transport companies as well.

There are many reasons why Delancey Street is able to be so successful in a field otherwise fraught with failure. For one, we understand that change is not an easy or a short-term process. To change not only the self-destructive behavior of substance abusers and criminals, but to change their antisocial attitudes and self-denigrating feelings as well, requires a long time, a very hard lines, and a complete re-education.

All our residents receive a high school equivalency, despite the fact that the average resident is functionally illiterate upon entering Delancey Street. They must receive vocational training in at least three marketable skills, are taught to interact successfully with others, and learn a great deal about themselves. We are unique because we are willing to stress the old-fashioned values of decency and dignity, of achieving a sense of self respect through working hard and earning it, of reaching out and helping others as a way to feel good about oneself. We teach self reliance by taking the large risk of not having anyone fund us, but of earning our money based on the strengths of our residents at the same time as we teach them to turn around their weaknesses.

I am really proud of what we have accomplished and would welcome the opportunity to show you our organization firsthand. The humor and energy and sense of hope which permeate our work are simply not able to be captured on paper.

THREAT TO NATIONAL SECURITY: DRUGS IN THE WORKPLACE

Lois Morris, M.A., C.A.C.
Anthony E. Miles

Daytop Village
New York, NY

The central concept of this paper--the idea that occupational drug abuse seriously threatens the stability and integrity of the United States--developed from my visits to companies and unions to describe Brightside Lodge. Brightside Lodge is the name of the new program Daytop Village has developed to help employers and employees deal with the crisis of drug abuse in the workplace. When I began visiting companies and unions to describe Brightside, I felt that my job was to highlight the unique and best features of Brightside's treatment and training and consulting services.

I have come to realize, however, that we who work in the occupational drug abuse field have a job that is more vital than simply describing our product. Anyone who is working in the occupational drug abuse field, up to capacity and in good faith, is helping to fight a problem that, if unchecked, will in no uncertain terms undermine the stability and the national security of the United States.

The Relationship between Productivity and Peace

The resources of the world--land, food, clothing, and shelter--are limited. Citizens within any country must strive to receive their full rights as citizens and an equitable share of national resources. Even at peace time nations must compete in world economic markets for their individual share of the world's limited resources.

Prosperity and peace are thus not unrelated. To promote one usually promotes the other. The economic well-being of its people is often a nation's greatest single protection against civil strife and war. Economic isolation and military force go hand in hand. When nations cannot get what they need through the normal processes of trade, they will resort to force. a people driven to desperation by want and misery is at all times a threat to peace. By contrast, a people employed and in a state of reasonable comfort is not one among whom class struggle, militias, and war can thrive (1). this correlation between peace and the economic well-being of nations was seen and analyzed by then U.S. Secretary of State Hull shortly before the United States entered World War II.

The paper which follows develops Secretary Hull's theme of the interconnection between a nation's economic security and peace by addressing the current threat to the U.S. economy and national security posed by drug abuse among american workers. The paper also delineates productivity-oriented tools to deal with occupational drug abuse.

The analysis presented in the paper addresses specific conditions of drug use among workers in the United States in the 1980's. I believe, however, that it also applies generally to other developed and developing nations which are also experiencing the problem of drug abuse in the workplace.

Work and the American Economy: The 1980's

The United States in 1985 is militarily at peace. Yet it is engaged, like all other industrialized nations, in a fierce struggle to maintain internal economic stability and its position in world economic markets. If the United States lost that struggle, the high standard of living contemporary Americans have come to expect could no longer be guaranteed. Already many younger Americans accept the fact that fewer will be able to replicate their parents' high standard of living. Fewer young Americans now own, or can expect to own their own home. It is becoming increasingly more expensive to support and educate children. Having children is thus often postponed or decided against. The nation's families are consequently becoming smaller. At the same time, increasing numbers of Americans are becoming unemployed. Laid-off workers who do become re-employed often find themselves in new jobs that are less skilled and that pay less.

Counseling unemployed American workers in the 1980's still means providing them with support during a distressing transition period, honing their employability, and practically assisting them to find jobs. In some other Western industrial nations, however, counseling the unemployed means teaching people to adapt to long-term or permanent unemployment. The United States itself is hardly untouched by the economic distress many industrialized nations are experiencing. The U.S. balance of world trade--its export to import ratio--has become highly unfavorable. Detroit, America's industrial capital, has been severely shaken by massive layoffs of steel and car factory workers. Many o these workers have been forced to trade in the high wages of a skilled, unionized workforce for unemployment payments or for the lower wages of unskilled labor.

U.S. Drug Abuse in the 1980's

The United States in 1985 faces many peacetime threats to its integrity as a nation. One of the most serious is growing drug abuse among middle-class Americans, including many permanent workers and professionals formerly removed from the hurricane eye of the United States' drug abuse problem.

Something new is happening in America, divergent from its recent past. There was limited national concern in America during the 1050's and 1960's when 61% of the youth of Harlem were using drugs. Only later did important people, respected members of their communities and professionals, begin to feel the impact of a son or daughter arrested for drugs--or themselves face arrest for possession, use, or sale of illegal drugs (2). Housewives and working women began to discover that they too could become addicted to legal drugs--or illegal ones. Growing numbers of blue collar workers, like white collar workers and professionals, have also become chemically dependent. Because America's drug abuse problem in the 80's has heavily infiltrated al segments of the U.S. population, all classes, and all ages, our country now faces the most serious drug problem in its history.

The fact that drug abuse has spread to and deeply penetrated all segments of the American population, including the most stable and productive elements, is cause for the greatest concern for the welfare of the nation. For a nation whose workforce and professions contain large numbers of alcoholics and addicts will not be productive or successful in the international business arena. Continuation of current drug abuse trends can even interfere with adequate national defense.

Any country can be thoroughly defeated internally when citizens' business initiative is based on the inconsistent and failing inspiration and stamina supplied by stimulant drugs such as cocaine and amphetamines. A nation of workers, business leaders, military personnel, and professionals made passive by drugs such as marijuana, heroin, and alcohol, cannot marshal needed creative aggressiveness and initiative for its work and cannot competently defend itself. Such a nation cannot succeed in appropriating for itself a satisfactory quality of personal, family and community life--or a high economic standard of living.

A nation whose school children in some cases begin, by the age of nine years of age, to buy illegal drugs in school buildings and grounds, a nation whose school children can buy drugs from classmates and sometimes even from teachers and counselor, is a country defeated if it does not change. This is the status of American schools in 1985--especially, but not only, in large urban centers. Substance abuse among preadolescent and adolescent children, like addiction among U.S. workers, is, without reservation, alarming.

The problem of occupational drug abuse which threatens U.S. national security is not, however, without solutions. A serious, well-funded national prevention and rehabilitation effort can be mounted to end this severe threat to America's integrity and strength. The successful technologies and strategies which the United States is now developing to fight occupational drug abuse, can and will be shared with other nations faced with a similar problem.

Brightside: Daytop's Occupational Drug Abuse Programs

My agency, Daytop Village, is a major East Coast drug treatment program which has successfully fought drug abuse for 22 years, treating over 40,000 youthful and adult substance abusers. Daytop is now turning its attention and harnessing its full organization resources to provide effective, low-cost treatment for employed persons who abuse or are addicted to drugs.

The primary tool that Daytop has developed to fight drug abuse among the nation's professionals and working people is Brightside Lodge. Brightside Lodge is the name for 3 principle occupational services that Daytop has developed. The 3 services are: 1) Brightside Lodge, a 30-day residential program for professionals and working people; 2) the Brightside Outpatient Program; and 3) Brightside Productivity, Training & Consulting Services.

Brightside Lodge: Short-Term Residential Treatment

1) Brightside Lodge. Brightside Lodge is an intensive 30-day rehabilitation program that forms the nucleus of Daytop's occupational treatment services. Brightside Lodge represents Daytop's first step in meeting the $16 billion problem of drug abuse in the American workplace. It is, however, just the start of Daytop's response to the problem of industrial drug abuse. Brightside Lodge will eventually fit into a larger complex of occupational services that will be named the Thomas M. Macioce Center for Personal Renewal.

Brightside, while treating all forms of occupational drug abuse, including dual addiction to alcohol and drugs, will focus specifically on the widespread problem of cocaine abuse in white collar and blue collar industries. Brightside staff have extensive experience in treating cocaine abuse. This expertise is available to assist the cocaine abuser to recover and to help family members and significant others support the cocaine abuser's recovery while they get the understanding and help they also require.

Brightside will provide specialized treatment for cocaine abuse on both an outpatient and inpatient basis. It will also treat individuals addicted to other drugs. Typically, a chemically dependent employee will participate in the following three-phase Brightside Lodge program:

Phase I: 30 days of intensive treatment

Phase II: 11 months of outpatient treatment

Phase III: 1 year of voluntary aftercare

Occupationally impaired individuals who do not require intensive residential treatment will instead begin treatment in Brightside's Outpatient Unit.

2) Brightside Outpatient Unit. Most substance abusing employees entering the Brightside program will begin treatment in the 30-day Brightside lodge rehabilitation program. After 30 days of residential treatment, the individual will enter outpatient care for 11 months.

Brightside is also able to draw upon the resources of Daytop Village to treat severely chemically dependent employees who need more intensive care than Brightside's typical 30-day residential treatment followed by 11 months of outpatient treatment care. Clients needing more intensive treatment can be referred to Daytop for long-term residential care or to one of Daytop's ambulatory care programs.

3) Brightside Training and Consulting Services. In addition to providing direct treatment, Brightside offers training and consulting services in four principle areas:

Drug Abuse Risk Prevention Consultations
Supervisory Training
Productivity and Quality of Work Life Consulting Services
Substance Abuse Seminars

Drug Abuse Risk Prevention Services. Brightside will send a prevention team into the workplace to assess organizational structures, work roles and environmental factors that predispose work sties to high rates of employee substance abuse. The team will recommend adjustments in work structures that are needed to reduce the risk of drug abuse. The team will also help the employer or union start a drug prevention program.

Supervisory Training. Brightside provides training to supervisors and union personnel in intervention strategies to maximize occupationally impaired employees' recovery potential. The training is also designed to minimize productivity losses to the company.

Productivity and Quality of Work Life Consulting Services. A Brightside consulting team will help companies and unions cut the productivity losses they face from employee substance abuse by 1) redesigning organizational structures and roles to enhance organizational productivity and the quality of work life within the organization; 2) designing and implementing heavily productivity-oriented drug abuse prevention programs in the workplace; and 3) providing employee assistance program (EAP) referral and treatment services.

Substance Abuse Seminars. Brightside's multidisciplinary consulting team will visit companies, unions, work sites, and agencies to present seminars on drug abuse and related issues.

The Rationale for Short-Term Residential Treatment

Recovery rates of alcoholics treated in occupational rehabilitation programs are often as high as 70-80%. These recovery rates are considerably higher than those for unemployed or marginally employed alcoholics. The greater family and social support that employed substance abusers more often enjoy, and the employee's need for a steady job, are pivotal factors supporting the chemically dependent employee's recovery.

Unlike alcoholics who have their own short-term rehabilitations, however, before Brightside drug dependent workers found it difficult to find low cost, short-term and drug-specific residential treatment. Drug abusing workers usually had to enter alcohol rehabs to find the short-term residential treatment they needed. These alcohol rehabs have proven to be tremendously successful at rehabilitating alcoholics, but not at rehabilitating drug abusers or ly dependent employee's recovery.

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A long-term drug treatment program was the unsatisfactory alternative left to the drug dependent employee who did not want to enter an alcohol rehabilitation unit. The price for utilizing this alternative was often termination of the employee because of his or her extended absence from work.

Brightside Lodge was instituted to help solve this problem. Brightside's 30-day rehabilitation program is designed specifically to help employees protect their jobs while they seek treatment for substance abuse. The cost of ending addiction, as Brightside sees it, should never be termination from one's job.

Brightside's Strong Therapeutic Community Roots

Brightside Lodge is one of the first drug treatment therapeutic communities being developed in america to provide short-term drug-specific residential treatment for employees who are drug dependent. Brightside's program, while based on the TC model, also utilizes effective new treatment modalities from a wide variety of health care disciplines. Brightside has additionally developed its own innovative treatment methodologies, such as Work Motivation and Attitude groups, to maximize clients' recovery potential.

Brightside has retained all critical core characteristics of the TC, including a strong emphasis on family and work and accountability to peers. It has, however, enriched core TC components such as Daytop's traditional TC family milieu therapy and encounter groups to provide the most effective possible treatment for a new treatment population--chemically dependent employees.

Brightside Treatment Components

The Brightside treatment team will be comprised of an experienced professional and treatment program graduate staff working side by side as equal partners. This model has proven to be far more effective than any other treatment modality developed to assist drug abusers. Brightside treatment components will include:

One to One Counseling
Stress Management
Encounter Groups
Pastoral Counseling
Psychological Counseling
Sexual Counseling
Work Motivation and Attitude Groups
Group Therapy
Drug Abuse and Alcohol Education
Family Counseling
AA and NA Groups
Aerobics and Team Sports, Swimming and Hiking
Networking Groups
Single Life Styles Groups

Brightside Women's Lodge: an innovative treatment program to deal with the special needs of female employees.

The TC as a Resource for Increased Productivity

The therapeutic community's usefulness to industry extends beyond the treatment it can provide for workers addicted to drugs. The TC can also serve as a catalyst promoting industry's adoption of more efficient work structures. Brightside Lodge, like other therapeutic communities, can assist national productivity in all of the following ways.

Brightside Prevention, Productivity, and Training and consulting Services will assist employers and unions in setting up formal drug abuse prevention programs for employees that include analysis of risk factors for substance abuse within the work environment. Brightside can help the company and union resolve problems in how employees fit into company organizational structures since unresolved problems in these areas can mean both low productivity and high employee turnover. The dominant supervisory style of the company is also carefully analyzed for its impact of productivity levels and quality of life in the work environment.

How time is structured in the workplace must also be carefully considered since it can become either a severe substance abuse risk factor or a cornerstone of high productivity. Businesses that employ workers on late shifts or double shifts or that assign employees extended work shifts split by layover time in distant cities are generally at higher risk for substance abuse. Unusual work schedules make it more difficult for employees to constructively structure family life and leisure time and thus place them at higher risk for substance abuse.

Work environments are also at high risk for employee substance abuse when people work under demanding work conditions: under extreme stress, in occupations where there is a strong drug-use image; in jobs that are monotonous and repetitious; in jobs where there is a high level of antagonistic interaction with the public or co-workers. Employers interested in the maintenance of a productive work environment and in low turnover of employees cannot afford to ignore these risks. For once abstract risk becomes actual employee drug use, it is unlikely that the employee will remain productive at work or in any other aspect of life.

TCs and the Business Community: A Working Partnership

The role therapeutic communities can play in assisting their host nations to maintain high levels of productivity through the TCs productivity-related Prevention, Training, and Consulting Services represents a new direction for the therapeutic community. Yet it is a direction that may become the TC's most important work. This is so because genuine productivity means much more than a game of employers trying to get more out of workers' hides while workers resist.

National productivity is a critical variable closely associated with a citizen's standard of living and quality of life. It is a variable that is also often co-related with a country's willingness to seek peace with its neighbors or readiness to be pushed to war because of economic distress.

National productivity, if properly apprehended and appropriately pursued, can mean a good life for all citizens in the nation and peace with neighboring countries. If misconstrued and mismanaged, this critical fact of national life can alternatively mean grievous suffering to employees displaced by greed-centered business or through the shortsightedness of humane employers unable to adapt their work operation to technological advances.

An expressed concern for productivity can be a disguise for exploitation of human resources. Misapplied productivity approaches can lead to open war on workers and open warfare between unions and business. Yet a company of nation's drive for higher productivity, creatively managed, can mean strong business and strong unions cooperating to invent productivity initiatives that are not short-sighted and ultimately wasteful of human, social, and financial reserves. A proper balance of self-interest and cooperation is required of company and union. Employed people possess enormous knowledge of work and enormous potential creativity and initiative. Properly tapped by industry, these resources will make the employed successful and lead to higher levels of national productivity, a stronger nation, and a satisfied work force.

Symptoms of national decay, including high unemployment rates and large numbers of professional and permanent workers becoming addicted to drugs, must be reduced if national productivity is to rise and the nation's citizens are to continue to enjoy a comfortable standard of living. At the very least, the employer can look forward to reduced drug abuse at work sties where the therapeutic community intervenes with prevention programs and direct treatment of chemically dependent employees.

The TC cannot solve all national productivity problems; it can assist in resolving some. The TC can provide direct assistance in one important productivity area–work impairment due to drug abuse. The TC is now doing this by designing innovative programs to effectively rehabilitate drug abusing workers.

The therapeutic community can also significantly assist national productivity by analyzing risk factors in job design, hierarchy of work roles and organizational structure which contribute to employee substance abuse. By creatively pursuing the narrow goal of reducing employee drug abuse, the TC can more broadly assist industry in evolving worker-humane, productive, and financially profitable work structures and systems.

The therapeutic community, with its successful history as a community dedicated to achieving both functional and human goals, embodies a model that the workplace can learn from. In the same manner, we, the therapeutic community, have much to learn from the business community which we wish to serve.

COMPUTER TECHNOLOGY & THE TC

David Kerr, M.S.W.

Integrity House,
Newark, New Jersey

This paper contains descriptive information and copies of printouts from a computerized system for managing your TC and related programs. This system was originally created and modified for Integrity Inc., and was installed in 1982. Presently the system is being modified and enhanced to accommodate a more extensive client management system as well as programs utilizing methadone maintenance.

The system appears to be unique particularly in offering financial reports that are segregated by cost centers and particular program locations. In addition, it has a unique management oriented statistical report that automatically prints once a month, as well as a client management and tracking system segregated by counselor caseloads, program locations and cost centers. It is therefore particularly well-suited for multi-modality programs that want to maintain unique financial and client management data by contract or by cost center.

If you are interested in finding out more about this system, call or write to me at 201-623-0600 or call Queue Associates directly at 201-229-1212, and ask for Jim McMillan or Leslie Wilcox.

This system is available for the IBM PC/AT, IBM XT AND IBM System 36. It is designed primarily for users who need the advantages of a diversified accounting system in an integrated package. A set of individual menus allows the user to switch from one system to another easily. This system is designed for clinic sue and is easily understood by all in this environment. Each of the users has successfully installed this system, including parallel processing, within three months of purchase.

This package includes the following files:

Client Master File

This file contains information about each client's status (client number, name, address, etc.) used for generating reports and statements. It also contains demographic and admit/discharge account information for quick review.

Guarantor Master File

This file contains information about each guarantor (guarantor number, name, address, contact name).

Charge Data File

This file contains data on charges entered into the system and used in generating invoices. Each charge entered contains the following information: description of charge, guarantor number, amount of charge, branch/dept/year this cycle.

Dictionary File

This file contains information which defines demographic informtion pertaining to your Client file. Each demographic entry has one "header" record (field number, description, etc.) and one detail record for each field defined.

Invoice Master

This file contains all the necessary information for generating receivables. Each record contains invoice number, guarantor number, client number, date, amount, etc. One record is maintained for each invoice created. In this way, all reports reflect current amount status.

System Control File

This file contains various control information such as the starting invoice number, clinic name and phone numbers, methadone inventory, etc.

Temporary Billing File

This file holds the information required for this cycle and is used only when the billing process is being executed by the clinic.

In addition to standard listings of all files, the following reports are included in the standard package:

Aged Trial Balance

You may choose to have a summary aged trial balance or a detailed trial balance printed. Either report results in a summary account line aged over current, 7, 14, 21 and 28 day periods. This reports prints in customer order and subtotals for each.

Customer Master List

This is a listing of customer information from the customer master file. This listing maybe produced in customer number sequence or in alphabetical order.

Invoice Register

This report is a listing of all invoices on file. The register may be printed in invoice number sequence or customer number sequence.

Payment Auditing

This produces an audit listing of payments and adjustments and can be used to verify bank deposits. It also shows the status of each invoice that was updated during this routine.

Labels

Labels can be printed for the following files: guarantors, clients, urinalysis, and methadone dispensing.

Demographic Analysis Report

This is the report which prints all demographic information by client number. It will subtotal and total by Program codes, defined by the dictionary file.

Dictionary File Master List

This is a listing of all dictionary records currently on file.

Admittance/Discharge Report

This report prints all clients with discharge and admittance information.

Charge Report

This is a listing of all charged loaded in this billing cycle. This can be printed in three ways: by client, by charge and by staff member.

Interim Billing Register

This is a listing of all charges being billed currently. It prints in client/guarantor order and subtotals for each client.

Guarantor Master List

This is a listing of all guarantors on file. This can be printed in two ways: by guarantor number or alphabetically by guarantor name.

Statements

This system will produce statements on pre-printed forms by guarantor.

There are four sub-menus to this package accessible from the system menu which appears as follows:

Client Management / Accounts Receivable
System Menu

[01] Load and Maintenance for Files

[02] Charges and Payments Processing

[03] Billing and Accounts Receivable

[04] Miscellaneous Reports

[05] Change Entity and Backup Procedures

[06] End Processing

Nearly two years ago Integrity, Inc. purchased an IBM System/23 microcomputer. The computer was purchased for the purpose of running all of our financial systems including billing and receivables, accounts payable and general ledger.

Integrity has worked with a programmer to specifically tailor the receivables system to our needs. The following are some of the benefits of the software:

1) It is especially useful for those agencies looking for extensive billing systems to accommodate growing fee for service funding.

2) The system allows individual billing per cent or per contractor, keeping track of receivables on an individual basis or as aggregated by department, facility or contract.

3) This system keeps track of all monies paid in on an individual basis or per contractor or department as well.

4) This system is helpful in justifying third-party payment from insurance companies since it will show actual billings and receipts which tie in to fee schedules.

5) In any billing system there is certain basic information that has to be gathered on each customer or contract. In this system some basic demographic information was gathered for future statistical analysis. This system will print out a statistical analysis for any agency by program or department for any time period designated. Certain valuable information will be provided here including type of referral, race, sex, source of referral, county, drug of abuse, cost of habit, jail time, months spent in program, etc.

6) These statistics can be used for marketing in that they will show the amount that cents or members were spending on their habit per week or day as well as the cost to the taxpayer of the months they spent in jail prior to entering the program. We have found that this information has a tremendous impact on duning sources and trustees.

7) By using certain procedures, individuals "treated" in certain facilities in an agency can be tracked through the "re-entry" phase and into their aftercare phase. Tagging these people initially in the residential TC phase will enable an agency director to see how many of his/her members make it through the program and finally to graduation. This is especially helpful for directors of larger agencies when one facility seems to be showing dramatically better retention through the program than another facility, for example.

8) This software program can also print mailing labels sorted by zip code for inexpensive bulk rate mailings which may be needed from time to time in mobilizing family support for clients in treatment. Integrity was able to print out 1,000 labels in a matter of 15 minutes and with the help of members these labels were affixed to envelopes and mailing was facilitated which was vital to our funding needs.

9) If an agency is required to use certain numbers to identify clients, these same numbers can be used in the computer system, facilitating state audits of numbers against actual clients. The state of New Jersey still uses CODAP numbers so these are the numbers we have assigned to clients in our computer system.

Integrity operates approximately ten different facilities, some of which do not relate to drug or alcohol treatment. We have identified the facilities by code; for example, our Federal Pyramid halfway house is called PHIF and our Federal Probation is called TCFP while one of our residential TC'S is called TC1A and our Re-entry Program is called TC2.

In addition, Integrity has adopted an accounts payable and general ledger system which we have modified slightly to accommodate our specific needs. This system is also appropriate in that it will provide specific profit and loss statements for each one of our facilities as well as a consolidated statement, plus a month by month and year-to-date detailed statement compared to budget figures. This system is extremely straightforward, easy to operated and well-tested. It allows you to spread expenses by a predetermined

formula automatically in one step or manually, department by department. Invoices are loaded for payment once and all other necessary entries are done automatically, including posting to the general ledger. JOurnal entries, transferring revenue or accounting for the deposit of money into various departments is also facilitated through this software.

As long as at least one or two staff members are thoroughly familiar with this software, residents or members can do most of the entries and all of the tedious loading and maintaining of the accounts receivable. Integrity has found that a tremendous interest has been kindled on the part of the residents for progressing in the computer operator or programmer field as a result of their experience with our equipment.

Presently, Integrity, in conjunction with Queue Associates, is developing a management system which will focus on the following areas: producing monthly or quarterly reports, including treatment plans and treatment plan reviews; printing dose levels and medication prescription levels for all clients; printing urine labels, printing labels for methadone maintenance clients; printing statistical reports, including CODAP admission and discharge reports and client summaries; projecting the names of all clients with the appropriate updated treatment plan goals; printing the names of all clients with the number of direct counseling hours they have received per month; printing other statistical and demograpahic reports from combinations of any of the fields identified in the data filing software package. In addition, this software will produce personnel reports including staff sick days, vacation days, counseling hours, records of completed staff evaluations, salaries and insurance benefits.

AUTOMATING QUALITY CONTROL: RESIDENTIAL AND OUTPATIENT SETTINGS

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This presentation will address quality control and the cost of quality control. The entire health care industry, and especially that part of the industry which receives funding form government sources, has been annually incurring ever increasing administrative costs -- costs that can be attributed in part of demands from funding, licensing, and other oversight agencies for more detailed monitoring of health care delivery systems. Government regulations, insurance requirements and legal safeguards have all forced a great per cent of each treatment dollar to be spent on administration. Correspondingly less can be spent on actual treatment.

Over the last decade, however, solutions have become available which can help reduce the myriad of paperwork associated with administering and monitoring health care programs. The newest advances in computer technology, along with organizational techniques that take full advantage of the power and versatility of the new more affordable person-al and office computers, can provide the therapeutic community and other types of service programs with an effective weapon to stem this rising tide of administrative costs.

System Development

As early as 1976, Health Care Delivery Services, Inc. (HCDS), a parent company for several drug and adolescent treatment programs in the state of California, was applying a computerized management information system that provided clinical management reports on a monthly basis. The system revolved around a series of simple forms that allowed us to automate the client intake process, as well as provide detailed clinical information on each HCDS client during the month. At that time, this sophisticated system of clinical management reports was using relatively expensive mainframe computer time. As of 1981, however, with the availa-bility of relatively inexpensive microcomputers, we converted the system to a microcomputer configuration. We were not only able to maintain the same level of sophistication, but actually found that the microcomputers gave us even more flexibility to format the system for special needs.

Client Population

For the paper presented here, we've focused on our experience with four of our residential adolescent treatment programs situated in both northern and southern California. They range in size from 10 to 70 clients. They include both short term assessment programs (2 to 3 months) that experience a high intake/discharge load (50 to 75% turnover in one month), to relatively long term programs (1 to 2 years) with low client turnover (under 5% per month).

System Design

During the transition from mainframe to micro, we developed two computer based management systems that deal with client tracking and accounts receivable tasks. The Client Data System manages clinical and background information on each client, while the Client Accounting System tracks fiscal data.

Setting and Cost Control System

Client Data System. The client data system initializes at client intake. Background and demographic information is entered into the computer, including birth date, sex, race, source of referral, county or origin, diagnosis at admission, and any other basic information needed on each entering client. Once entered into the computer, this master database becomes a large electronic filing cabinet with a wealth of client information immediately available for agency inquiries, completion of various types of required forms, or other information requests.

This main client database is also the source used for a series of internal reports that help HCDS track client information. A month utilization report provides each director with a census of clients and automatically calculates key statistics (e.g., per cent utilization, etc.) for easy reference. Admission/discharge summaries are also automatically generated each month using this master database and provide information for the director to review the nature of clients entering the exiting the program.

Besides keeping track of background and demographic information, the client data system also monitors clinical activity on individual clients, including tracking individual and group therapy sessions, and client contacts with counselors, medical and other staff. Contacts with others important to the client's situation are also monitored (e.g., welfare workers, probation officers, family, etc.). This information, along with other information important to clinical activities in the program (e.g., rule breaking activity, school behavior, employment activity, etc.) are summarized in a single monthly report. The clinical director is able to review

this summary for the entire facility, as well as reviewing information for each individual counselor's caseload.

Client Accounting System

Information on each client that is relevant for billing or accounting purposes is automatically routed into the Client Accounting System from the master database. Time in treatment is calculated based on admission and discharge dates, and monthly billings are printed with time in treatment converted to total actual dollar amounts where appropriate. The accounts receivable billing report for residential claims is broken down by individual counties in the state of California to facilitate individual county billings.

Probably one of the most important components of the accounting system is the time it can save in maintaining individual client ledger cards. Monthly claims are automatically transferred into the accounting system, which provides a separate history of claims on each client. This virtually eliminates the maintenance of individual client ledger cards on each client. Payments are entered on each client's claim, and the individual history for each client calculates total amounts due, while the accounts receivable aging provides a summary (month-by-month) of amounts outstanding.

The number and variety of automatic functions in this accounts receivable system has provided an incredible amount of time savings for tracking monthly billings. The computer can go through a list of client claims and pick out bits of information that once took hours to pull together. With the use of time/motion studies, we found that staff time on just the maintenance of client accounts receivable alone was reduced by over 25%.

Budget Setting and Cost Control System

One of the earliest systems to be automated at HCDS, Inc. was a system to monitor spending patterns. This Cost Control System provides a direct comparison to budget for each expense line item. Comparisons can be made for the current month and for the fiscal year to date. These reports are printed each month as part of our larger general ledger package, and go through a systematic review process every month, along with a more detailed review process every quarter. The entire system has become an invaluable part of our efforts to control spending through the budget setting process.

One of the most important, but most tedious administrative tasks for most treatment directors is the budget setting process. Checking spending patterns from the former year and setting budgets within funding limits can take a great deal of time for executive and support staff alike. For this reason, one of the most valuable enhancements to our cost control system was the development of the Budget Setting System. The budget preparation worksheet is one of the reports generated by this system. It provides each director with average spending on each line during the fiscal year, along with old budget figures and a place to enter the new budget. Printing the budget preparation worksheet is the first step in the budget setting process each year. Once completed, the new budget is entered into the budget setting system, and other report generating features provide complete hard copies of the new budget.

Budget

The maintenance of high quality control standards is a concern for all of us working in providing the public with health care services. While the costs of maintaining quality control systems have been increasing, the newest advances in computer technology have provided a means for increasing the effectiveness of quality control systems without significant increases in costs, and in many cases, with substantial cost savings.

Although we've only had time here today to briefly discuss client tracking and accounts receivable systems, we've had a great deal of success in automating other tasks in various treatment programs. For instance, we have been using an automated and completely integrated accounts payable and general ledger system for some time, providing us with computer check writing capabilities. Also, we recently established a variety of custom systems for maintaining units of service and other types of client tracking for our adult services drug treatment division. Besides our own custom systems, we have been able to automate a number of administrative tasks just using packaged word processing and spreadsheet programs.

Overall, our experience in automating various tasks over the last 9 years has provided us, in all respects, with a much more efficient running organization. But the road has not been an easy one. Choosing the right hardware and software, and the decision to custom design software to fit the requirements for running a health care program have been hard choices to make. We're especially proud of the systems we've been able to develop over the years, and would be glad to respond to any inquiries so that others can learn from our mistakes and successes.

EAP PROGRAMS CAN AND DO WORK IN A TC

Allen Bray

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The SHAR House Industrial Program is an intensive two-phase, JCAH accredited, drug-free treatment program which was established in 1978 to provide treatment services to the employed substance abuser. The program components include a 45-day residential phase, followed by a six-month to one-year outpatient phase. The employed substance abuser seeking treatment faces limitations regarding the length of treatment due to his job obligations, family obligations, and other related situations. Thus, the traditional TC residential program, which is typically one year or more, is not accessible to the employed substance abuser. The 45-day residential period allows the substance abuser to become involved in an effective approach to treatment without further jeopardizing his job or financial status. It also allows the individual to begin developing the necessary coping skills, self-discipline, and insight to foster a drug-free lifestyle. The residential phase, in conjunction with the outpatient phase, provided the individual is motivated, can lead to long-term recovery from chemical dependence and the subsequent benefits which result from recovery.

Clients take a medical leave from their jobs to enter treatment. The program admits those who are 18 years and older, have a sincere desire to terminate substance use, who have insurance coverage or alternative means to pay for treatment, and who are physically and mentally fit enough to participate in the treatment regimen. Those who have serious medical or psychiatric problems are not accepted into the program. In cases where physical or mental health is questionable, the staff physician and psychologist make the final determination. In cases where medical detoxification is required, the client is referred to an affiliated hospital program for this service. In conjunction with detoxification, the client begins to participate in the treatment process immediately and consequently enters the 45- day residential phase with a higher level of motivation.

Upon admission, the client enters the orientation phase of the program. The client goes through orientation with other residents from other programs. Because these programs coexist within the same facility, this helps to facilitate cohesiveness within the facility. Those in the industrial program are moved through orientation faster to expedite their entry into treatment. While in orientation, those in the industrial program are given individual sessions and attend didactic lectures. This is done to better utilize and intensify their limited time in the residential phase. They are also allowed visits on weekends with family members. The orientation phase generally lasts one to two weeks. Upon the client's demonstration of adequate knowledge of program philosophy, rules and regulations, and house tools, he/she is graduated into treatment.

Once in treatment, the client begins an intensive, highly structured treatment regimen. The client attends one therapy group daily, one or two encounter groups weekly, an individual session at least weekly, a didactic lecture daily, an A.A. or N.A. meeting weekly, and in cases where it is indicated, family therapy with significant others. The program also offers the family association to significant others to help them acquire insight into addiction and supportive techniques. Participation in services is mandatory and takes priority in the daily life of the client. Clients in the industrial program also perform a job function, as do the residents in other programs. However, time spend on job functions is less due to the concentrated services they must attend.

It is important to note that residents in the SHIP Program are subject to the same rules and regulations and TC techniques as the other residents. When not in their groups or individual sessions, they must interact and function within the facility and with the other residents. This approach is effective in that the confrontation and the inherent stresses within the therapeutic community help in the reduction of denial and the minimization of the addiction and its consequences. Also, it assists in the development of coping skills and insights into addiction.

Upon completion of the 45-day residential phase, the resident is discharged and returns to his home and job. At this juncture, he/she enters the outpatient phase of treatment. Group times are schedules to accommodate all work shifts. The client is required to attend twice weekly. Urine samples are taken twice weekly to insure that the client is abstaining from the use of substances. Two positive urine samples and two unexcused absences are grounds for termination from the program. However, some flexibility is needed here. If a client has been progressing and has remained drug-free for an extended period of time, it is in the best interest of the client to allow treatment to continue to help him divert the onset of relapse and active addiction. Typically, clients in the outpatient phase of treatment will have periods of crisis. during these times, outpatient treatment plays an essential role in circumventing the resumption of drug use. Clients in the outpatient phase of treatment are also urged to maintain their attendance at N.A. and/or A.A. This is seen as a vital support system.

It is important to address the role of the employer in the treatment of the employed substance abuser. The employer or someone affiliated with the workplace is frequently the catalyst which initiates the treatment process. This may be a union official, medical personnel, management, or typically an employee assistance representative. The employer can provide invaluable information to treatment personnel regarding the

referred client. More importantly, the employer can provide additional support and motivation to the client. As termination from employment is often the primary motivation for seeking treatment, it is recommended that the employer be involved in the treatment process. Visits by the employer during the course of residential treatment are effective in reinforcing the consequences of further substance abuse. Frequent contact with the employer during the outpatient phase is essential and plays a significant role in the effectiveness of treatment. Communication with the employer can alert the treatment personnel to problem behavior on the job which can then be addressed in treatment. Coversely, treatment personnel can appraise the employer of problems with the attendance or drug use, which the employer can then address. This is effective in keeping the client involved in treatment and preventing relapse.

Preliminary review suggests that the 45-day treatment modality is equally effective when compared with long-term treatment. An important contingency, however, is client participation on a regular basis in the 6 to 12 months of outpatient counseling after residential completion.

In light of rapidly dwindling public revenues for substance abuse treatment across the country, service provides with third party potential will better assure their survival by considering this or similar treatment approaches.

WHAT EMPLOYEE ASSISTANCE PROGRAMS EXPECT FROM DRUG PROGRAMS

Larry Levy

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The four major areas most troublesome for employee assistance programs, TC's and drug/alcohol programs are: a commitment to work together as a therapeutic team, family involvement in the treatment process, individualized treatment for alcoholics and addicts, and aftercare services for the substance abuser and their families.

Commitment is needed for both the employee assistance program and the drug/alcohol program to work together as a therapeutic team. The major problem areas are: often dissension rivalry and jealousy; roles are not clearly defined; mutual distrust as to client's needs; confidentiality violated; and E.A.P. attempts to provide treatment, thus conflicting with TC objectives.

The Employee Assistance Program's Responsibilities

1. Consult and strategize with the manager faced with a nonproductive and troubled employee.
2. Define personnel policy and disciplinary alternatives.
3. Conduct an intervention on the job with the focus on job performance issues.
4. Evaluate client's problems and motivate him toward treatment.
5. Refer client to an appropriate facility, program or therapist.
6. Provide intake counselor with background information.
7. Verify insurance coverage.
8. Arrange for medical leave of absence, sick leave or short term disability.
9. Adhere to TC's admission procedure.
10. Contact and involve family in the treatment process.
11. Monitor client's progress, attendance, motivation and participation in treatment.
12. Participate in TC staff meetings.
13. Attend and participate in "back-to-work" conference.
14. Provide input into discharge and aftercare planning for both client and family.
15. Provide limited and general feedback to management, while ensuring client confidentiality.
16. Once client has returned to work, monitor job performance and aftercare attendance.
17. Receive copies of discharge summary and aftercare plan.
18. Resolve problems with insurance coverage and treatment costs.

The Employee Assistance Program's Expectations

1. Expeditious and reasonable admission process.
2. E.A.P. background information valued and disseminated.
3. Immediate notification of client's admission.
4. Provide weekly progress reports.
5. Contact family and arrange for an individual interview.
6. Welcome E.A.P. participation in treatment planning and attendance in staff meetings.
7. Provide written discharge summaries and aftercare plans.

8. Specifically define and respect E.A.P. role.

9. Work toward the common goal of helping clients.

Family Involvement

Most E.A.P.'s acknowledge addiction as a family disease and that the entire family must be treated. The E.A.P. should have already contacted the family and encouraged their participation before the client is admitted to the TC.

Problem areas include: some programs delay contacting the family; some programs either ignore families or handle them in a token fashion; often the family is simply referred to Alanon or Narcanon; no attempt is made to meet with the family alone to assess their needs and encourage treatment. Quality programs provide "family education series" which include films, lectures, individual and group counseling; some programs have families spend a full week at the program.

The E.A.P. expects the TC to have immediate contact with the family upon the client's admission, to provide an individual interview with the family and to develop a separate and individualized program for all family members. In addition, the TC should provide referrals to appropriate self-help groups, provide a comprehensive program of counseling and information at least three nights each week, consideration of an outside referral for longer term marital or family therapy, inclusion of the family in a strong aftercare program, periodic feedback to the referring E.A.P. and conjoint sessions while the alcoholic/addict is in treatment.

Individualized Treatment for the Alcoholic and Addict

Most E.A.P.'s recognize the individualized needs of clients and expect that TC's provide individualized treatment. Most programs boast about individualized treatment but fail to provide it because of lack of qualified staff or funds. Group therapy is most effective with addicts, but it does not negate the need for individual treatment.

Problem areas include: often individualized treatment consists of a 15 minute counseling session with the assigned counselor; individualized needs are often ignored, shelved or handled peripherally; some programs are content to move cents through steps 1 through 5 of Alcoholics Anonymous; often only the most disruptive and pathological receive special attention.

Aftercare

In my opinion, the most important part of treatment is aftercare, yet it is given the least amount of attention by treatment staffs. This is the toughest time for clients who are trying to adjust to the real world without chemicals. The standard format is usually weekly "rap" groups at the facility and recommendations to attend a lot of NA and AA meetings. Often aftercare is viewed as an "appendage" to treatment. Attendance in weekly groups usually tapers off after 3 months, but staying clean and sober is a lifelong process.

The E.A.P. expects individually tailored aftercare programs for both client and family. Aftercare planning should begin at the onset of treatment and then refined throughout treatment. The E.A.P. should participate during aftercare planning. The aftercare plan should include references to outside clinical activities, and progress and attendance in aftercare needs to be reported to the Employee Assistance Program.

ENTERPRISE IN THE NON-PROFIT ZONE

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This presentation suggests a few of the many organizational structures available to those non-profit organizations considering business ventures. The details of any proposed structural and functional relationship are highly technical and should benefit from the advice of a learned legal counsel. This presenter is neither an attorney nor an accountant, but rather an enterprising human service advocate. This presentation is made in the hope of generating some thoughtful consideration of the issue and eliciting helpful suggestions.

Before discussing alternate corporate structures, we should consider why they may be needed or desirable. A corporation should not reorganize because everyone else is doing so, or because it simply feels like it. The process should be careful and deliberate. One should consider the nature and relationship of the organization's current and planned activities. Are they similar? Is one an outgrowth of the other? Is one meant to generate money for the other? The answers to all these questions can be yes and still not warrant alternative structures.

The primary consideration in any corporate reorganization of a non-profit service agency should be to protect and nurture the original organization. Thus, some functional objectives of restructuring can be to shield the assets of an operating service provider from litigation or other liability, to properly position the organization's rates in a regulatory environment, to enable the advent of different and possibly revenue generating activities, and to generate funds for non-reimbursable activities such as research and advocacy.

An important consideration is the present tax exempt status of the operating agency and protecting it from revocation. The one tax that all non-profits are liable for is the tax on unrelated business income. There are three conditions that an activity must meet in order to be deemed unrelated and therefore taxable.

The first test is being a "trade or business." Quite simply this means an activity that produces an income generated by provision of a service or product. In this test, the nature of the product and/or service is not considered. The second test is a determination that the activity is "regularly carried on." This is determined by the frequency, continuity, and comparability of the activity. The latter is a comparison to the manner in which proprietary organizations engaged in a similar business or trade conduct the activity. The third test determines whether the activity is "substantially unrelated" to the operating organization's tax exempt activity. The purpose to which revenue is put is not considered in this test, only the actual nature of the new and original activities.

Some organizations conducting unrelated activities may choose to keep them in-house. There is no clear cut rule used by the IRS as to how much unrelated income will jeopardize current tax exempt status. A general rule of thumb generated by some IRS "scholars" is 16% or less of unrelated income may be garnered without risking tax exempt status. This is not a concrete rule and different IRS regions can render different rulings. There are other reasons to avoid additional corporations. They may be too burdensome administratively. Several activities under one corporate roof may allow offsetting the profits of one with losses of another, thus remaining under the 16% threshold.

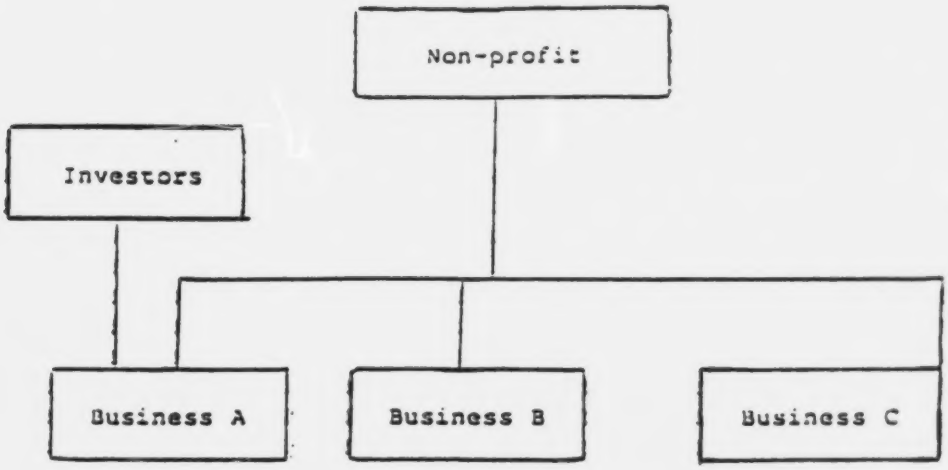
This presentation, however, is premised on the assumption that a tax exempt organization, after careful consideration, has determined to spin off a business activity. There are several matters that must be considered in structuring the new corporation and relating it to the original. Dominant among these is whether money is to flow from the business to the tax exempt corporations, the degree of relatedness of the organizations, and the actual form of the new entity.

The latter may be profit making or non-profit, a trust, a corporation, a cooperative, or an unincorporated entity. The issue of proclaiming a corporation as a for-profit is ironic in that neither law nor IRS codes require such a corporation to be profitable or even to intend to make a profit.

Money flow and direction must be planned for. The new business entity may pay for or collect fees such as rental of space, equipment, and personnel. If stock is issued by the profit making business, the non-profit may receive cash in the form of dividends. The latter is considered passive income and is less likely to jeopardize tax exempt status.

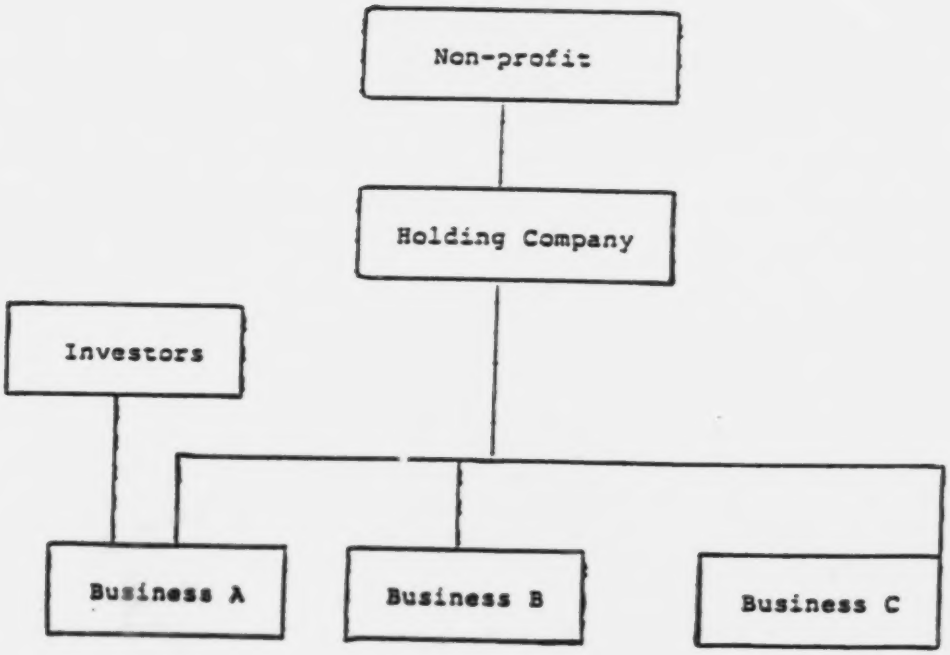
The new entity may be totally controlled by or independent from the non-profit. Such control issues are managed through stock ownership, by-laws, and membership criteria in the corporations, and interlocking directors. A usual consideration is the prevention of external entities from piercing the corporate veil.

Figure 1



Structure A

Figure 2



Structure B

Let us now examine a few potential structures and briefly discuss their strengths and weaknesses. A structure that may be the simplest includes the non-profit as a parent or umbrella corporation with one or more proprietary subsidiaries. The latter may be wholly or partially owned by the parent (See figure 1).

In business venture A, the parent may own some or a majority of the stock. In B and C it clearly is the sole owner of the stock. Some of the advantages of this structure are that the non-profit can continue to garner governmental assistance and be attractive to some donors for tax purposes. A disastrous business venture by one of the corporations would not jeopardize the assets of a more successful one because they are housed separately. A major disadvantage is that the parent can not pool the losses of one with the earnings of another to minimize the tax liability of the profitable one. This can, however, be done by a parent that is for profit and therefore subject to taxation.

To overcome the disadvantage noted above, a for-profit holding company is often inserted between the parent non-profit and the business ventures. Thus, by owning all of the stock of the holding company, the non-profit can have its holding company subsidiary pool losses and earnings to minimize its tax expense (See Figure 2).

Two structures that may be used to deal with rate setting and asset preservation concerns are referred to as the sibling and parent-child reorganizations. The former is more effective in preventing the piercing of the corporate veil, but requires a greater leap of faith. That is, in the sibling structure, one corporation gifts all of its physical and cash assets to a sister or brother corporation which is trusted to use these assets for its own and its brother or sister corporation's benefit. The disadvantage of this structure is that there are no assurances that the gifted assets will be used as intended, hence the "leap of faith."

The parent-child model allows for more direct interaction between the corporations through membership criteria, but is more susceptible to having its veil pierced. In this structure, a newly created parent corporation can receive all of the assets and become the sole member of the child corporation. This can assure that the parent votes in the board of directors of the child, thus assuring that the assets and operations are used in tandem, although at arm's length.

In any reorganization, several factors must be carefully considered. The choice of structure may depend on any combination of local politics, administrative efficiency, desired path of capital flow, possible funding sources, local laws, and of course, federal tax considerations. In some instances, a community may be opposed to certain services being provided by a profit making company. An example may be the new phenomenon of prisons for profit for adults and adolescents. In addition to the usual opposition to the establishment of such a facility in any community or neighborhood, the opponents may decry the profit motive in incarcerating people.

In another community, local garages and service stations may be up in arms over a competing business established by a therapeutic community. TCs have access to a "cheap" labor pool and, if set up as a non-profit, tax exempt status. This enables undercutting the competitor's prices and making up the difference through volume and the non-payment of taxes. Another consideration may be the limited scope of political and lobbying activity that can be carried on by a tax exempt organization. A proprietary corporation has virtually no limits on its electoral and/or legislative involvement.

The concluding thought in this presentation is to proceed cautiously with good expert advice. The first crucial decision is programmatic because it determines whether an organization wishes to diversify its services and/or products. This can be done by the board, staff, and clients of the organization. The next two decisions warrant expert external counsel. These crucial decisions are whether reorganization is necessary, and if so, what form it should take.

TC OR TLC: AN IDENTITY CRISIS

John T. Brewster, M.S.W.

Addiction Treatment & Research Center
University of Colorado School of Medicine

Jesse Jaramillo

Peer-I TC
Denver, Colorado

It is helpful, when evaluating the ideas presented in a discussion about drug abuse treatment, to understand a little bit about the background of the presenters.

Brewster, a social worker, began his drug abuse treatment career in 1968, in the first public treatment program in California to offer both inpatient methadone detoxification and a therapeutic community, The Mendocino State Hospital Drug Program. Closed in 1972 by then Governor Reagan, "The Mendocino Family" was the forerunner, essentially the progenitor, for the many therapeutic communities historically and currently operating in the Western United States: The Napa Family, Arizona Family, Camarillo State Hospital Family, Metropolitan State Hospital Family, Tarzana Family, "Our Family" (Imola, California), Portland VA Family, Texas Family, Ayrie TC (Denver VA), Peer-I Family (Denver, Colorado). Leave it to say that the residuals of Mendocino continue, having evolved with the times, but characterized by the same basic tenants that produced its original success and influence.

I (Brewster) have remained in the substance abuse treatment field and currently hold a faculty position as a senior instructor with the School of Medicine, University of Colorado, and serve as the associate director of the Addiction Research and Treatment Services, University of Colorado Health Sciences Center (hereafter referred to as ARTS).

Mr. Jaramillo became interested in drug abuse treatment in 1972, while serving a 26 year sentence at the New Mexico State Penitentiary as the result of heroin addiction. As an inmate, he helped to develop the penitentiary pre-release program which incorporated ideas and methodology from TCs such as Synanon and Delancy Street. He ultimately became director of that program and was subsequently released from prison in 1975.

Following his release from prison, Mr. Jaramillo relapsed, leading to his admission to the Peer-I Therapeutic Community. Graduating in 1980, he sought employment as a counselor, leading to his current role as clinical coordinator. Mr. Jaramillo has been drug free for 7 years.

Before beginning, we would like to briefly describe our program: ARTS has 87 residential beds; Synergy, a 26 bed long-term adolescent substance abuse treatment program; and Peer-I, a 61 bed therapeutic community, the program providing the basis for our presentation.

ARTS' Outpatient Clinic offers multimodal treatment approaches, including methadone maintenance treatment for 150 clients, a Naltrexone Clinic, and array of specialty clinics consisting of a Cocaine Clinic, Halsted Clinic (treating impaired health professionals), Family Intervention Program, a Professional Athletes Clinic, and a Criminal Justice Clinic. We treat approximately 300 clients in the Outpatient Clinic. ARTS also provides medical and community education, along with conducting a variety of research projects, with a current focus on tobacco dependence, cocaine treatment, and the etiology of alcoholism (studying primate colonies).

The title of this presentation, "TC or TLC: An Identity Crisis," will focus on our attempt to demonstrate that TCs nationally are in a state of transition which, in our opinion, is leading to the possible disintegration of the entire TC movement in the United States. And what a movement it has been! Beginning in 1958 with the development of Synanon, the therapeutic community raced across the United States, becoming the primary form of drug-free treatment employed in most urban areas. Its brash, unapologetic style, while offensive to some, provided treatment for the first time to the heretofore "untreatable" drug abuser. For the first time in psychiatric history a clinical approach, spiteful of Freud and his "henchmen" for their historical discrimination and diagnostic insults, began to modify a specific typology of drug abuser, the "hard core," criminally involved, chronic addict. Not only did the TC invite the most unattractive clients, it engendered their respect and was able to offer a responsible life style that did not incorporate drugs, prostitution, violence, deceit and the whole lineage of despicable behavioral characteristics represented in the drug abuser's universe.

Mr. Jaramillo and I represent what some might call the "old school" in regard to what a TC is, and ought to be. In fact, it is our strong belief in the basic tenets of traditional TC methodologies that prompted us to submit this paper. Over the past few years we have been struck by what appears to be a significant change in the types of treatment programs calling themselves TCs. In fact, the term appears to be losing its meaning.

Where once a TC was universally defined as a lengthy (minimum of a year), strongly confrontational, "self-help" program run by clients, monitored by staff (who were usually recovering drug abusers), characterized by harsh motivational testing, discipline, initiations (puberty rites), where everything was done compulsively (or else), we have begun to see the emergence of short term (60 to 90 days), non-confrontational programs, operated by credentialed mental health professionals (social workers, psychologists and the like), who have entered the TC movement via the educational rather than the experiential route.

What we are seeing is alarming: 1) a trend toward treating the "soft core," employed, insurance carrying client as opposed to that "hard core," disenfranchised, criminally oriented "reject" that TCs were created for; 2) a re-emergence of mental health ideologies and criteria defining this form, as well as other forms, of drug abuse treatment--a trend which appears to be influencing the substance abuse field in general and which has many dangerous implications, not the least of which is a dramatic reduction in the length of stay and the loss of confrontational behavioral treatment techniques; and 3) possibly the most alarming trend, the loss of the recovering abusers influence and point of view. This appears to be true of both recovering alcoholics and drug abusers.

In Colorado, for example, the tremendous growth of proprietary hospitals for the treatment of alcohol and drug dependency has virtually removed the recovering population from a position of influence. It's now profit margin, census, EAP hustles, advertising, competition.... It's dollars, folks! The recovering people have been so successful, particularly in the alcohol field, that they have worked themselves into a dilemma. Although I'm sorry to say it, most of the influential recovering people no longer work with the primary commitment of "saving lives," they work instead for a corporation, for money and corporate growth.

This phenomenon is also happening in the drug abuse field. It is happening to the TC movement, and it is possibly the most serious assault on our sovereignty that we have ever faced. Yes, even more serious than reduced funding. And isn't it ironic that, in order for the TC to survive fiscal cutbacks by changing its length of stay, composition, and client type, we have become vulnerable to extinction. Because it appears that what we're doing is trying to attract the less severe, insurance carrying drug abuser and fitting them into a short-term program, just like our alcoholism treatment colleagues are doing. You might argue, so what? It's OK to have money and power; hell, it's American. Yes, money and power are fine goals, but not as primary motivators in human services. Our integrity can be corrupted too easily by them, and besides, have we forgotten that the TC client doesn't carry insurance or have much legally attained money? The TC client is a criminal! The TC client has no alternative except the most intensive forms of psychological interventions. If there is an effective, short-term drug-free alternative that can fit the TC eligible client, the field should adopt it immediately. But we don't think that such an approach exists.

TCA Survey

Because we thought that there was the possibility of a changing character in the therapeutic community movement, we decided to conduct an informal survey, or poll, of TCs across the country. We selected the programs to be surveyed from the TCA letterhead because TCA is the national organization representing therapeutic communities throughout the nation. All programs on the letterhead were called, totaling 50.

The survey took place during the weeks between July 10 and July 25, 1985. All of the interviews were conducted by telephone, and all respondents identified themselves as staff members of the program, ranging from intake coordinators and counselors to directors and executive directors.

Of the 50 programs called, 21 (42%) responded to the questions. Although there were a variety of reasons given for refusing to respond, the primary ones were because of program confidentiality or a lack of administrative authorization. Table 1 shows the questions asked, with aggregate program responses.

Discussion

When discussing the findings of the poll, it should be kept in mind that this was a very limited effort and is being used here because it tends to support certain of the authors' observations about changing trends in the TC movement.

Responses to the survey point toward the possibility that TCs are indeed changing. Programs are more and more using mental health professionals as executive officers, where historica..y recovering abusers were responsible for clinical and administrative activities. Although the breakdown was close (52% non-recovering, 48% recovering), the change is dramatic and will have a significant impact on the clinical operations of TCs. This is not to suggest that the changes will necessarily be negative. Mental health professionals have a great deal to offer the TC. Our concern is focused on the possibility that with a change in the type of clinical/administrative leadership, ideological differences may intrude on the management of the TC. These changes then may cause programs to swing widely from their historic concentration on the client's unique treatment needs and unusual clinical interventions toward looking for ways to produce revenue and shorten stay, possibly at the expense of the client.

To continue, some of the speculated changes may already be occurring. The use of confrontation/discipline based behavior shaping techniques (signs, verbal aggression, costumes, etc.) are

utilized very infrequently in the programs we sampled: 17 programs (81%) of the respondents reported the absence of such techniques, with only 4 (19%) indicating that they were still in use.

Intensity of treatment also appears to have changed, with a low to moderate intensity characterizing 14 (67%) of the respondents. Seven programs (33%) described their intensity as "hard core." Although we left the definition of "hard core," moderate, or "soft core" to the respondent, the results still appear to have a relationship with our hypothesis. It is our strong belief that only the "hard core" substance abuser is a candidate for a TC and that practically all others can be treated effectively as outpatients, or with minimal residential treatment.

A pleasant finding involved the responses to the question about the use of confrontation groups. The majority of programs, 16 (79%), reported using "games", encounters or other forms of confrontation groups as a basic part of their treatment. Because confrontation is considered basic to all TCs, we were pleased at this finding, although it left 5 programs (21%) reporting no use of group at all. Another possible warning of decay?

Based on the above findings, it is our contention that therapeutic communities are changing their structures and subsequently losing their identities, possibly as a result of the movement's need to survive. Specifically, we have postulated 5 influences leading to the changes.

1) The most important influence is the advent of private health insurance coverage for alcoholism and drug dependency treatment services with strict provisions covering maximum length of stay, e.g., 21 to 45 days.

2) Third party payment has led to profiteering, at times without regard to clinical efficacy.

3) With shortened treatment episodes and the reduction of "hard core" clients, there is a significant decrease in the use of aggressive behavioral techniques such as verbal and visual disciplines, confrontation groups, etc.

4) The public's (Congress') apparent disinterest in clinical activities, while at the same time concentrating on drug prevention, led to massive cuts in treatment funds for indigent drug abusers.

5) The recovering abuser's leadership has been supplanted by the mental health professional.

With the onslaught of hospital based, profit oriented substance abuse treatment programs, the therapeutic community may be in danger of extinction. Why? Because TCs are deemed appropriate for only about 10% of the total client pool. It is our contention that the vast majority of the remaining drug abuse population can be effectively treated as outpatients, without the need for more restrictive, not to mention expensive, inpatient (residential) treatment. If the trend toward short term "softer" TCs continues, it would seem logical that funding sources, particularly government agencies, might begin to compare the programs, which may lead them to the false conclusion that you can do in 30 days what the traditional TC has taken 12 to 24 months to produce.

To argue that short term residential (inpatient) treatment is the most effective modality for substance abusers is fraught with problems. Alcoholism outcome research has clearly stated that, for the most part, several weeks of inpatient treatment has about the same outcome at one year as outpatient counseling only. Although drug treatment outcome research is in its infancy, what studies have been done tend to support the idea that length of stay is the most significant predictor of success--the longer stay correlating with the better outcomes. So it would appear to be a mistake for us to support the increasing ambiguity about what constitutes a therapeutic community. A short term, middle class residential drug program is simply not a TC!

Philosophical Metamorphosis

Although we believe that it is the introduction of insurance payments and reduction of public funding that are chiefly responsible for the identity crisis, there is also a change in clinical philosophy that requires discussion.

Freudenberger, a significant influence in our field and brilliant in regard to many of his concepts on burnout, made comments that the mystique and romanticism had gone out of the ways we were treating drug addicts. We will paraphrase certain of Freudenberger's ideas because they tend to illustrate what we believe are increasingly the thoughts of many contemporary TC leaders and are, in part, responsible ç for our burgeoning identity crisis.

Freudenberger, suggesting that therapeutic communities should shorten treatment, stated, "These realities (limited funding and loss of mystique) do not allow us the luxury of 2 and 3 year residential treatment programs." He negated the use of the "encounter" (for our East Coast friends) or "game," (for us Synanon products), making the statement that, "the residents have become sophisticated defensive, conning, manipulative and evasive techniques so they can survive encounter without being changed by it."

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Because we thought that there was the possibility of a changing character in the therapeutic community movement, we decided to conduct an informal survey, or poll, of TCs across the country. We selected the programs to be surveyed from the TCA letterhead because TCA is the national organization representing therapeutic communities throughout the nation. All programs on the letterhead were called, totaling 50.

The survey took place during the weeks between July 10 and July 25, 1985. All of the interviews were conducted by telephone, and all respondents identified themselves as staff members of the program, ranging from intake coordinators and counselors to directors and executive directors.

Of the 50 programs called, 21 (42%) responded to the questions. Although there were a variety of reasons given for refusing to respond, the primary ones were because of program confidentiality or a lack of administrative authorization. Table 1 shows the questions asked, with aggregate program responses.

Discussion

When discussing the findings of the poll, it should be kept in mind that this was a very limited effort and is being used here because it tends to support certain of the authors' observations about changing trends in the TC movement.

Responses to the survey point toward the possibility that TCs are indeed changing. Programs are more and more using mental health professionals as executive officers, where historically recovering abusers were responsible for clinical and administrative activities. Although the breakdown was close (52% non-recovering, 48% recovering), the change is dramatic and will have a significant impact on the clinical operations of TCs. This is not to suggest that the changes will necessarily be negative. Mental health professionals have a great deal to offer the TC. Our concern is focused on the possibility that with a change in the type of clinical/administrative leadership, ideological differences may intrude on the management of the TC. These changes then may cause programs to swing widely from their historic concentration on the client's unique treatment needs and unusual clinical interventions toward looking for ways to produce revenue and shorten stay, possibly at the expense of the client.

To continue, some of the speculated changes may already be occurring. The use of confrontation/discipline based behavior shaping techniques (signs, verbal aggression, costumes, etc.) are

First, his poor understanding of the use of confrontation groups is clear because of course we all know that the "encounter/game" has many purposes, the least of which is to cure a drug addict. Among other things, it allows for a large group of aggressive deviants to live in the same environment without killing each other. It's also a management tool, allowing client operated treatment systems to communicate hierarchically and with staff.

Further, he postulated that there are no longer hard core addicts around. Well, if he (and we) don't consider characteristics such as conning, manipulation, evasive techniques as "hard core" traits, we had better start all over. If the "hard core" addict has disappeared, where have they gone? At Peer-I we've got lots of them. Of course, we now define them differently than we did 10 years ago, but it's a joke to believe that there are no longer hard core drug abusers. Hell, they're probably harder core now than they were. Younger, yes. Poly-drug, most certainly. More sophisticated pharmacologically, absolutely! Soft core? No way.

So, Freudenberger has suggested shortening the length of stay and doing away with the confrontation groups (encounter/game), adding that we should, "...teach the rudiments of proper diet, of cleanliness, of the basic economic facts, of vocational skills, of everyday living routines, of personal grooming and dressing, and most important, of forming an accurate self-concept." And accomplish all of these, as he postulates, in a short term program. He suggests, "We need to get out of our we must produce successful graduates bags." Wow! That's about as close to heresy as you can get. Don't we all know that it is the enthusiasm and commitment of producing the successful graduate that is essential for the remarkable and impressive successes of the many TCs throughout the country? I would guess that many of you listening to this presentation are products of just such evangelism.

Sure, we shouldn't be deceitful; clients aren't "widjets" to be mass produced. But the major reason TCs have been so strict in relation to success criteria and the clinical process is that compromise with the clientele we were designed to treat is suicide. That's where rigidity came from. And believe it, most mental health professionals are not trained with the type of consistent, strict ideological adherence required to operate a TC correctly. Only the behaviorists have the type of orientation that is required, and most of them are not comfortable with the need for aggressive surveillance and the associated demands required in the maze of the TC matrix.

We believe that it is the Freudenberger naivete that is characteristic of the non-recovering mental health professional, which is therefore likely to seriously contaminate the TCs identity and quite possibly the lives of many drug abusers. That's the Tender, Loving, Care most of us don't need to change our lives.

So, you ask, what model of TC do you believe in? Are you as provincial as you sound? Well, yes...and no. We believe that TCs, like good football teams, should handle the basics before they try the fancy stuff. We define the basics as follows:

1) Admission criteria to the TC modality should be for a drug abusing population requiring the most intensive and restrictive treatment--the chronic, severe (hard core), personality disordered, usually criminally involved, substance abuser. Less severe, and otherwise disinterested clients, should be treated in different, less restrictive environments, e.g., outpatient, short-term residential, methadone maintenance. You don't admit people to TCs unless they clearly need to be there! We speculate that 80% to 90% of al drug abusers can be treated effectively in outpatient settings. So you see, we are actually opposed to inpatient, or residential, care except in those unusual cases requiring it.

2) Control over all admissions and discharges. Voluntary versus involuntary is essentially a moot issue since it is clear that nobody has been able to define the difference. Whether Aunt Tilly threatens to revoke your inheritance or a superior court judge says, "50 years or the TC," makes no difference. One way or the other, you're in. And, of course, we are all becoming increasingly aware that the more involuntary one is the better they do--a simple tenet of contingency management therapy. The important factor is that the client has an alternative to treatment, e.g., the streets, jail, work.

3) A treatment program which provides a drug free extended family, where his/her developmental processes can begin anew in a strict system of balanced positive and negative reinforcers. Day to day living should be rigorous and confrontational, well supervised, with a hierarchical system of non-token client government participants serving as role models, teachers, and parents to the younger residents.

The treatment should be safe, involving confrontations and discipline, along with reward systems. It is an important treatment goal to get the client's absolute commitment to change his/her life. This commitment usually takes several months to occur, but is essential in order for the client to begin change in earnest. status, discipline, identification, confrontation, and self-help are several of the hallmarks of TC treatment. The program should be characterized as highly responsible, with the goal of perfection, and the realism of human error. Length of treatment for the appropriate client should be, at minimum, 9 months to one year, followed by a re-entry period of 6 months to a year.

4) Staffing in a TC should consist primarily of recovering, credentialed therapists, supplemented by non-recovering experts in administration (who ways an ex-addict knows how to run a business?), and psychologically sophisticated professionals who function as consultants, e.g., psychologists, social workers, counselors. We feel that went you remove the dedication, zeal, and knowledge of the recovering abuser from

clinical leadership, you no longer have a TC. Instead, you have another form of intensive residential treatment program for substance abusers.

Conclusion

In summary, the TC program should teach a client how to live as a responsible and drug-free member of their community. This is brought about by treatment that provides a consistent (strictly controlled), drug-free, long-term treatment environment, teaching the client via continuous feedback to heighten self-awareness and produce a positive identity while stripping his/her character defenses and reducing impulsivity. Specific interventions, modalities if you will (affective, cognitive, behavioral), should always be offered, adding and deleting modalities as evidenced by the needs of the population in treatment and as pragmatic issues dictate. But we cannot stop discipline, confrontation, and the system of idealistic extremes, for without these our clients, bless their little hearts, will not get better. In fact, their disease will simply, and secretly, be acted out in treatment rather than on the streets. A re-entry period of 6 months to one year must follow the intensive TC experience. The focus of re-entry must be reintegration and the establishment of a social support and financial system.

We are also warning the therapeutic community field that we may be losing our most important resources--the recovering substance abuser. We don't want to revert to what once was--a system of treatment which had no idea what the TC candidate was all about, a system that consisted of dedicated but naive practitioners whose commitment was to their job, not the changing of human conditions. Synanon was born of this benign neglect.

Let's not bring about a complete 360 degree return to the past. We would suggest that the field should strictly define a therapeutic community so that it doesn't simply disappear. We don't oppose the traditional mental and medical professionals having a piece of the action. Hell, they're offering great advances in differential 5approaches to substance abuse. We simply want the TC to remain for whom it was originally intended and for whom it has worked so effectively. We are not here to argue why change may or may not be necessary, since change does and will continue to occur. That the drug abusing population is changing is true, but that fact alone is not sufficient reason to do away with effective treatment principles.

Let us not forget what we teach our members, "Don't forget where you came from!" While others compete for the recently identified substance abuse dollar, let's not lose our sense of what we know is necessary in order to produce truly healthy ex-addicts. Let's not compromise our values and philosophies or, in the process, we not only lose the sense of our mission but also, and saddest of all, our clients failures might become the by-product of our greed.

TABLE 1

QUESTION	RESPONSE	
1.What is your role in the TC?	Administrative . . .	8(38%)
	Counseling Staff . .	13(62%)
2.Are you recovering?	Recovering	13(62%)
	Non-recovering . . .	8(38%)
3.Describe your program's discipline(verbal aggression signs, costumes)	External discipline (signs,verbal attack)	4(19%)
	Other(non-visible)	17(81%)
4.Does your program use confrontation group therapy?	Yes	15(71%)
	No	6(29%)
5.Are you a "hard-core", moderate, or soft-core program?	Hard-core	7(33%)
	Moderate	10(48%)
	Soft-core	4(19%)
6.Are you professionally run, or recovering run?	Professional	11(52%)
	Recovering	10(48%)
7.What is your estimate of indigents vs. paying clients in your program.	Indigent	--(78%)
	Paying	--(22%)
8.What is your estimate of referrals from:EAP,criminal justice, or other(self,etc.)	EAP	--(5%)
	Criminal Justice . . .	--(55%)
	Other	--(40%)

THE PARA-PROFESSIONAL VS. THE PROFESSIONAL: BREAKING THE BARRIER

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The conflict between the program graduate counselor and the M.S. or M.S.W. counselor is as old as the therapeutic community. Some of the basis of this conflict stems from the disparities in education and life experience of the two groups.

Social work training for clinical practice or intervention is not geared toward substance abuse treatment within a therapeutic community. The social worker, while valuing clinical techniques and approaches, is not trained to understand or value the therapeutic community concept. The social worker, newly entering a therapeutic community, is basically entering a foreign environment, one in which they do not understand much of the language nor much of what is happening. Many therapeutic community techniques seem contrary to good social work practices, i.e. loss of privileges, contracts, sanctions, etc. In addition, often the new M.S.W. has little respect for the program graduate counselor, considering him or her to be street wise, undereducated and overly glib.

In return, the program graduate counselor often has even less respect for the M.S.W. The substance abuse counselor maintains that "book learning only goes so far" and often views the M.S.W. as an inexperienced "bleeding heart" who has little understanding of drug addicts and is easily manipulated.

The substance abuse counselor is a graduate of the program. Thus, he/she has experienced personal growth and change within the therapeutic community and has a strong belief in therapeutic community concepts and therapeutic community methods. In addition, the substance abuse counselors, because they feel a part of the system, control the system.

The result, as experienced at Apple, was two groups of counselors with separate belief systems, with little respect for one another, but with one common goal--to help and assist the client to overcome the drug problem. The conflict, however, worked to the disadvantage of the clients and undermined the effectiveness of the therapeutic community, establishing camps that worked in opposition to one another.

In attempting to overcome this seemingly inherent conflict, Apple developed a treatment staff training program backed up by administrative policy which clearly defines the program's approach toward treatment.

The basic tool used to break down the barriers is the Substance Abuse Counselor Certification Manual of T.C.A. This manual was compiled under the leadership of David H. Kerr, Chairman of T.C.A. Credentialing and Accredition Task Force. The drive for credentialing was initially motivated in part, to establish a professional credential for the program graduate counselor. At Apple, however, it is a very useful tool in teaching therapeutic community concepts and techniques to the M.S. or M.S.W. counselor and promoting staff cohesiveness.

All treatment staff are required to become T.C.A. certified within two years in order to maintain employment. Directors must take the lead. Therefore, the Clinical Director, a certified psychologist, and the Program Director, a program graduate, have both become T.C.A. certified. Both directors are responsible for the "treatment staff" training sessions, bringing the substance abuse counselors and social workers into a discussion of unifying treatment concepts.

The competences developed in the T.C.A. manual are easily related to the M.S.W. educational background and the substance abuse counselors life experiences, allowing each to participate in the training as a trainer. For example, *Competence 1* is "Understanding and promoting self help and mutual help." Even though they may not recognize it, the substance abuse counselors and the social workers have learned in their training to work with the client without telling the client exactly how to solve his or her problem. Each has learned in their training to encourage the client to solve problems by themselves, stressing use of the tools of the environment As we begin to use this Competence in the staff training, we encourage both the social worker and the substance abuse counselor to discuss from their own backgrounds the means of implementing this Competence, of getting the client to help himself or encouraging the client to seek help from others.

Competence 3 is "Understanding of social learning versus didactic learning." Although many of the substance abuse counselors may not know the definition of didactic learning, both the social worker and the substance abuse counselors have learned about the natural process of growing up and maturing, of allowing people to interact with others, to express feelings, to be able to show frustration, even to be angry. The discussion of social learning versus didactic learning and their use at various times during the treatment process allows the substance abuse counselors to speak on the benefits of both social learning and didactic learning in the treatment process This enables both counselors to recognize that they may have learned to achieve the same goals from different roads; it enhances respect for each other, breaks down the barriers, and builds support.